THOMPSON RIVERS UNIVERSITY

# IMMUNIZATION REQUIREMENTS
# RESPIRATORY THERAPY PROGRAM

**Note:** Please complete this form and sign it before submitting. A Public Health Care Provider/Physician certification is also required to prove validity. Form is due by **Sept 30** or **Jan 30**, depending upon when you entered the program. This form only accepted with the required signatures. Please keep a copy for your reference. ****YOU MUST ENCLOSE PROOF OF IMMUNIZATIONS.****

Name: _____ _____ _____ Maiden Name: _____
(Last) (First) (Initial) (If applicable)

Date of Birth ____/____/_____ Student ID#: _____ Personal Health Number_____

Date of entry to program: _____
(Month) (Year)

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## 1. TB SKIN TEST

All students should have a **TB Skin Test** unless they are a known positive reactor or unless they have documented proof of a previous negative test result within the past 6 months, prior to commencement of the program. Those with a known positive reaction in the past should have a chest x-ray unless there is proof of previous chest x-ray results within 6 months.

TB Skin Test Date: _____ TB Read Date: _____ Result: _____ (mm)

Read By: _____
(Signature of Health Care Provider & agency stamp)

**A Chest X-ray is required if the TB skin test is positive,** or if there is a history of a previous positive reaction. A letter from the Health Unit will be provided to the student outlining TB Control recommendations when available. It is the student's responsibility to provide the information to the University.

Chest X-ray Date: _____ Result: _____
*Signature of Health Care Provider below indicates CXR has been read and is negative for TB.*

_____ **Signature of Health Care Provider for Chest X-Ray**

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*Please list all dates for immunizations in the following order: Year/Month/Day* (Adult >18 years)

## 2. TD – Tdap TETANUS DIPHTHERIA PERTUSSIS

**Primary Series** - Tetanus/Diphtheria/Pertussis (3 or 4 doses) in early childhood: Yes ____ No_____

**If answered yes**,(received in childhood),

**Date** of Dose #3 or #4 (this is the last date of Primary Series) _____ (Date)

**Td** Booster _____ (Date) **booster dose of tetanus**, is required **every 10 years** after primary series. This booster can be combined with other vaccines such as Polio.

**Name:** _____ _____ _____ **Maiden Name:** _____
**(Last)** **(First)** **(Initial)** **(If applicable)**

2. TD – CONTINUED from Page 1

If answered no, (did not receive the primary series in early childhood) completion of 3 dose series as an adult is required and include one dose of Tdap (to provide protection against pertussis):

Tdap (0 month) Dose #1: _____ (Date)

Td (1 month) Dose #2: _____ (Date)

Td (6 – 12 months after the 2nd dose) Dose #3: _____ (Date)

3. POLIO - IPV

Primary Polio Series (3 doses) in early childhood: Yes _____ No _____

If answered yes (received in childhood) a ONE TIME Polio booster is required 10 years after primary series

Polio Booster _____ (Date) Polio Booster can be combined with other vaccines

If answered no, (did not receive the primary series in early childhood) completion of 3 dose series as an adult is required.:

Polio IPV Dose #1: _____(Date) Polio IPV Dose #2: _____(Date)

Polio IPV Dose #3: _____(Date)

4. Measles, Mumps, Rubella (MMR)

2 doses of MMR are recommended for all Respiratory Therapy Students. Please record your dates.

Measles, Mumps and Rubella (MMR) Vaccine #1: _____ (Date)

Measles, Mumps and Rubella (MMR) Vaccine #2: _____ (Date)

5. Chicken Pox (Varicella Var)

If Varicella disease history or date of vaccines cannot be confirmed, then a Varicella IgG titre must be completed to determine immunity.

History of Disease: Yes _____ No_____ Date (if known) _____

OR Varicella immunity (IgG antibody) Yes_____ No____ Date _____

If susceptible: Varicella Vaccine Dose #1_____(Date) Dose #2(6weeks apart) _____(Date)

**Name:** _____ _____ _____ **Maiden Name:** _____
**(Last)** **(First)** **(Initial)** **(If applicable)**

6. Hepatitis B - HB

If necessary, the Hepatitis B series may be initiated upon entry into the RT program.
18 – 19 years of age 3 doses (0.5 mL each) given at 0, 1 and 6 months
20 years of age and older born in 1980 or later 3 doses (1.0 mL each) given at 0, 1 and 6 months
Students are considered immune to Hepatitis B if they have completed a 2 dose series of Hepatitis B (grade 6) list dates below.

3-dose series:
Dose #1 (0 month): _____ (Date)
Dose #2 (1 month): _____ (Date)
Dose #3 (6 months): _____ (Date)

2-dose series (6th grade)
Dose #1 (0 month): _____ (Date)
Dose #2 (6 month): _____ (Date)

Hepatitis B Titres _____ (Date) HEP B immunity Yes _____ No _____
Titers are blood tests that check your immune status for vaccinations or diseases you may have received in the past. You must have your blood checked for HepB immunity even if you've been immunized.

7. Annual (October to February) Influenza vaccine as required

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I certify that the information reported is accurate and up-to-date.

Please keep a copy for your reference.

_____ _____ _____
(Signature of student) (Print Name) (Date)

_____ _____
(Signature) (Name/Stamp Public Health or Physician Certification reviewing this document (Date)

Return to: Tara Langley , Program Assistant Respiratory Therapy
Ken Lepin Bldg. S212 859 College Drive Kamloops BC V2C 0C8
Email: resp@tru.ca Phone: 250 828-5403

**For Educational Institution Use Only:**
Date Form received: _____ In person ☐ post ☐ e-mail ☐
Data entered in computer HSPnet (if applicable) by: _____
Form complete ☐